YOUR BENEFIT PLAN

NORTHWEST PERMANENTE, P.C.

All Full-time and Part-time Non-summary Clinicians and Administrative Employees with Less Than 3 Years of Service

EMPLOYER: NORTHWEST PERMANENTE, P.C.

PLAN NUMBER: GRH-072800

PLAN EFFECTIVE DATE: January 1, 2016

BENEFITS UNDER THE GROUP SHORT TERM DISABILITY PLAN DESCRIBED IN THE FOLLOWING PAGES ARE PROVIDED AND FUNDED BY THE EMPLOYER.

THE EMPLOYER HAS FULL RESPONSIBILITY FOR PAYMENT OF ANY BENEFITS DUE ACCORDING TO THE TERMS AND CONDITIONS OF THE PLAN.

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SCHEDULE OF BENEFITS

The Plan of short term Disability provides You with short term income protection .

The benefits described herein are those in effect as of January 1, 2016

Cost of Coverage:
You do not contribute towards the cost of coverage.

Eligible Class(es) For Coverage:
All Full-time and Part-time Active Employees who are non-summary clinicians or administrative employees with less than 3 years of service excluding temporary, leased or seasonal employees.

Full-time Employment: at least 32 hours weekly, excluding on-call hours

Part-time Employment: at least 20 hours weekly, excluding on-call hours

Eligibility Waiting Period for Coverage:
None

Benefits Commence:
1) for Disability caused by Injury: on the 8th consecutive day of Total Disability or Disabled and Working;
2) for Disability caused by Sickness: on the 8th consecutive day of Total Disability or Disabled and Working.

Weekly Benefit:
The lesser of:
1) 60% multiplied by the amount of Your Pre-disability Earnings on which premium for You has been paid; or
2) 60% multiplied by the amount of Your Pre-disability Earnings;

reduced by Other Income Benefits.

Maximum Duration of Benefits Payable:
1) 25 week(s) if caused by Injury; or
2) 25 week(s) if caused by Sickness.

Additional Benefits:

Disabled and Working Benefit
See Benefit

ELIGIBILITY AND ENROLLMENT

Eligible Persons: *Who is eligible for coverage?*
All persons in the class or classes shown in the Schedule of Benefits will be considered Eligible Persons.

Eligibility for Coverage: *When will I become eligible?*
You will become eligible for coverage on the later of:
1) the Plan Effective Date; or
2) the date You complete the Eligibility Waiting Period for Coverage shown in the Schedule of Benefits, if applicable.

Enrollment: *How do I enroll for coverage?*
All eligible Active Employees will be enrolled automatically by the Employer.

PERIOD OF COVERAGE

Effective Date: *When does my coverage start?*
If You are not required to contribute toward The Plan's cost, Your coverage will start on the date You become eligible.

Deferred Effective Date: *When will my effective date for coverage or a change in my coverage be deferred?*
If You are absent from work due to:
1) accidental bodily injury;
2) Sickness;
3) Mental Illness; or
4) Substance Abuse;

on the date Your coverage, or increase in coverage, would otherwise have become effective, Your coverage, or increase in coverage will not become effective until You are Actively at Work one full day.

Continuity From A Prior Plan: *Is there continuity of coverage from a Prior Plan?*
If You were:
1) insured under the Prior Plan; and
2) not eligible to receive benefits under the Prior Plan;

on the day before the Plan Effective Date, the Deferred Effective Date provision will not apply.

Termination: *When will my coverage end?*
Your coverage will end on the earliest of the following:
1) the date The Plan terminates;
2) the date The Plan no longer covers Your class;
3) the last day of the period for which You make any required contribution;
4) the date Your Employer terminates Your employment;
5) the date You cease to be a Full-time or Part-time Active Employee in an eligible class for any reason; or
6) the date Your Employer ceases to be a Participating Employer;

unless continued in accordance with one of the Continuation Provisions.

Continuation Provisions: *Can my coverage be continued beyond the date it would otherwise terminate?*
Coverage can be continued by Your Employer beyond a date shown in the Termination provision, if Your Employer provides a plan of continuation which applies to all employees the same way. Continued coverage:
1) is subject to any reductions in The Plan; and
2) terminates if:
   a) The Plan terminates; or
   b) coverage for Your class terminates.

In any event, Your benefit level, or the amount of earnings upon which Your benefits may be based, will be that in effect on the day before Your coverage was continued. Coverage may be continued in accordance with the above restrictions and as described below:

Leave of Absence: If You are on a documented leave of absence, other than Family or Medical Leave, Your coverage may be continued for 3 months after the leave of absence commenced. If the leave terminates prior to the agreed upon date, this continuation will cease immediately.

Family Medical Leave: If You are granted a leave of absence, in writing, according to the Family and Medical Leave Act of 1993, or other applicable state or local law, Your coverage may be continued for up to 12 weeks after or longer if required by other applicable law, following the date Your leave commenced. If the leave terminates prior to the agreed upon date, this continuation will cease immediately.

Coverage while Disabled: *Does my coverage continue while I am Disabled and no longer an Active Employee?*
If You are Disabled and You cease to be an Active Employee, Your coverage will be continued:
1) while You remain Disabled; and
2) until the end of the period for which You are entitled to receive short term Disability Benefits.

After short term Disability benefit payments have ceased, Your coverage will be reinstated, provided:
1) You return to work for one full day as a Active Employee in an eligible class; and
2) The Policy remains in force.

Extension of Coverage for Total Disability: *Does coverage continue if The Policy terminates?*
If You are entitled to coverage while Disabled and The Plan terminates, coverage:
1) will continue as long as You remain Disabled by the same Disability; but
2) will not be provided beyond the date We would have ceased to pay coverage had the coverage remained in force.

Termination of The Policy for any reason will have no effect on The Employer's liability under this provision.

BENEFITS

Disability Benefit: *What are my Disability Benefits under The Plan?*
If, while covered under this Benefit, You:
1) become Totally Disabled;
2) remain Totally Disabled; and
3) submit Proof of Loss to the Claims Administrator;

The Plan will pay the Weekly Benefit.

The amount of any Weekly Benefit payable will be reduced by:
1) the total amount of all Other Income Benefits, including any amount for which You could collect but did not apply; and
2) any income received from the Employer for the period You are Totally Disabled.

Partial Week Payment: *How is a benefit calculated for a period of less than a week?*
If a Weekly Benefit is payable for less than a week, The Plan will pay 1/5 of the Weekly Benefit for each day You were Disabled.

Recurrent Disability: *What happens to my benefits if I return to work as an Active Employee and then become Disabled again?*
When Your return to work as an Active Employee is followed by a Disability, and such Disability is:
1) due to the same cause; or
2) due to a related cause; and
3) within 30 consecutive calendar days of the return to work;

the Period of Disability prior to Your return to work and the recurrent Disability will be considered one Period of Disability, provided The Plan remains in force.

If You return to work as an Active Employee for 30 consecutive days or more, any recurrence of a Disability will be treated as a new Disability.

Period of Disability means a continuous length of time during which You are Disabled under The Plan.

Multiple Causes: *How long will benefits be paid if a period of Disability is extended by another cause?*
If a period of Disability is extended by a new cause while Weekly Benefits are payable, Weekly Benefits will continue while You remain Disabled, subject to the following:
1) Weekly Benefits will not continue beyond the end of the original Maximum Duration of Benefits; and
2) any Exclusions will apply to the new cause of Disability.

Termination of Payment: *When will my benefit payments end?*
Benefit payments will stop on the earliest of:
1) the date You are no longer Disabled;
2) the date You fail to furnish Proof of Loss;
3) the date You are no longer under the Regular Care of a Physician;
4) the date You refuse the Claims Administrator's request that You submit to an examination by a Physician or other qualified professional;
5) the date of Your death;
6) the date You refuse to receive recommended treatment that is generally acknowledged by Physicians to cure, correct or limit the disabling condition;
7) the last day benefits are payable according to the Maximum Duration of Benefits;
8) the date Your Current Weekly Earnings exceed 80% of Your Pre-disability Earnings if You are receiving benefits for being Disabled from Your Occupation; or
9) the date no further benefits are payable under any provision in The Plan that limits benefit duration.

Disabled and Working Benefits: *How are benefits paid when I am Disabled and Working?*
If, while covered under this benefit, You are Disabled and Working, as defined, the following calculation will be used to determine Your Weekly Benefit:
1) multiply Your Pre-disability Earnings by the Benefit Percentage; and
2) compare the result with the Maximum Benefit; and

3) from the lesser amount deduct Other Income Benefits.

Current Weekly Earnings will not be used to reduce Your Weekly Benefit. However, if the sum of Your Weekly Benefit and Your Current Weekly Earnings exceeds 100% of Your Pre-disability Earnings, the Employer will reduce Your Weekly Benefit by the amount of the excess.

Days which You are Disabled and Working may be used to satisfy the Benefits Commence Period.

EXCLUSIONS AND LIMITATIONS

Exclusions: *What Disabilities are not covered?*
The Plan does not cover, and will not pay a benefit for any Disability:
1) unless You are under the Regular Care of a Physician;
2) that is caused or contributed to by war or act of war (declared or not);
3) caused by Your commission of or attempt to commit a felony;
4) caused or contributed to by Your being engaged in an illegal occupation; or
5) caused or contributed to by an intentionally self inflicted Injury.

If You are receiving or are eligible for benefits for a Disability under a prior disability plan that:
1) was sponsored by the Employer; and
2) was terminated before the Effective Date of The Plan;

no benefits will be payable for the Disability under The Plan.

GENERAL PROVISIONS

Claims Administrator: *What is the role of the Claims Administrator?*
The Claims Administrator is delegated the duties of the Employer to:
1) determine benefits payable according to the terms and conditions of The Plan; and
2) make payment for benefits payable.

However, the Employer has the responsibility for deciding appeals of claims which were initially denied by the Claims Administrator, and for making final determinations regarding eligibility for coverage.

Notice of Claim: *When should the Claims Administrator be notified of a claim?*
You, your supervisor or your physician must give the Claims Administrator notice of claim by calling the special claims telephone number provided to Employees. Such notice must be given on the fifth day of an absence due to the same or a related Disability.

Claim Forms: *Are special forms required to file a claim?*
The Claims Administrator will send forms to You to provide Proof of Loss, within 15 days of receiving a Notice of Claim. If the Claims Administrator does not send the forms within 15 days, You may submit any other telephonic proof which fully describes the nature and extent of Your claim.

Proof of loss is typically provided by telephone; however, if forms are required, they will be sent to You for providing Proof of Loss within 15 days after a notice of claim.

Proof of Loss: *What is Proof of Loss?*
Proof of Loss may include but is not limited to the following:
1) documentation of:
   a) the date Your Disability began;
   b) the cause of Your Disability;
   c) the prognosis of Your Disability;
   d) Your Pre-disability Earnings, Current Weekly Earnings or any income, including but not limited to copies of Your filed and signed federal and state tax returns; and
   e) evidence that You are under the Regular Care of a Physician;
2) any and all medical information, including x-ray films and photocopies of medical records, including histories, physical, mental or diagnostic examinations and treatment notes;

3) the names and addresses of all:
   a) Physicians or other qualified medical professionals You have consulted;
   b) hospitals or other medical facilities in which You have been treated; and
   c) pharmacies which have filled Your prescriptions within the past three years;
4) Your signed authorization for the Claims Administrator to obtain and release:
   a) medical, employment and financial information; and
   b) any other information the Claims Administrator may reasonably require;
5) Your signed statement identifying all Other Income Benefits; and
6) proof that You and Your dependents have applied for all Other Income Benefits which are available.

You will not be required to claim any retirement benefits which You may only get on a reduced basis. All proof submitted must be satisfactory to the Claims Administrator.

Additional Proof of Loss: *What additional proof of loss is the Claims Administrator entitled to?*
To assist the Claims Administrator in determining if You are Disabled, or to determine if You meet any other term or condition of The Policy, the Claims Administrator has the right to require You to:

1) meet and interview with the Claims Administrator; and
2) be examined by a Physician, vocational expert, functional expert, or other professional of the Claims Administrator's choice.

Any such interview, meeting or examination will be:

1) at the Claims Administrator's expense; and
2) as reasonably required by the Claims Administrator.

Your Additional Proof of Loss must be satisfactory to the Claims Administrator. Unless the Claims Administrator determines You have a valid reason for refusal, the Claims Administrator may deny, suspend or terminate Your benefits if You refuse to be examined or meet to be interviewed by the Claims Administrator.

Sending Proof of Loss: *When must proof of Loss be given?*
Written Proof of Loss must be sent to the Claims Administrator within 90 day(s) after the start of the period for which the Claims Administrator is liable for payment. If proof is not given by the time it is due, it will not affect the claim if:

1) it was not possible to give proof within the required time; and
2) proof is given as soon as possible; but
3) not later than 1 year after it is due, unless You are not legally competent.

The Claims Administrator may request Proof of Loss throughout Your Disability. In such cases, the Claims Administrator must receive the proof within 30 day(s) of the request.

Claim Payment: *When are benefit payments issued?*
When the Claims Administrator determines that You:

1) are Disabled; and
2) eligible to receive benefits;

the Claims Administrator will pay accrued benefits at the end of each month that You are Disabled. The Claims Administrator may, at their option, make an advance benefit payment based on the Claims Administrator's estimated duration of Your Disability. If any payment is due after a claim is terminated, it will be paid as soon as Proof of Loss satisfactory to the Claims Administrator is received.

Claims to be Paid: *To whom will benefits for my claim be paid?*
All payments are payable to You. Any payments owed at Your death may be paid to Your estate. If any payment is owed to:

1) Your estate;
2) a person who is a minor; or
3) a person who is not legally competent;

then the Claims Administrator may pay up to $1,000 to a person who is Related to You and who, at the Claim Administrator's sole discretion, is entitled to it. Any such payment shall fulfill the Claim Administrator's responsibility for the amount paid.

Claim Denial: *What notification will I receive if my claim is denied?*
If a claim for benefits is wholly or partly denied, You will be furnished with written notification of the decision. This written notification will:

1) give the specific reason(s) for the denial;
2) make specific reference to The Policy provisions on which the denial is based;
3) provide a description of any additional information necessary to perfect a claim and an explanation of why it is necessary; and

4) provide an explanation of the review procedure.

Claim Appeal: *What recourse do I have if my claim is denied?*
On any claim, You or Your representative may appeal to for a full and fair review. To do so You:
1) must request a review upon written application within:
   a) 180 days of receipt of claim denial if the claim requires to make a determination of disability; or
   b) 60 days of receipt of claim denial if the claim does not require to make a determination of disability; and
2) may request copies of all documents, records, and other information relevant to Your claim; and
3) may submit written comments, documents, records and other information relating to Your claim.

will respond to You in writing with the final decision on the claim.

Social Security: *When must I apply for Social Security Benefits?*
The Employer may require that You apply for Social Security disability benefits when the length of Your Disability meets the minimum duration required to apply for such benefits. You must apply within 45 days from the date of the request. If the Social Security Administration denies Your eligibility for benefits, You will be required:
1) to follow the process established by the Social Security Administration to reconsider the denial; and
2) if denied again, to request a hearing before an Administrative Law Judge of the Office of Hearing and Appeals.

Benefit Estimates: *How does the Claims Administrator estimate Disability benefits under the United States Social Security Act?*
The Claims Administrator reserves the right to reduce Your Weekly Benefit by estimating the Social Security disability benefits You or Your spouse and children may be eligible to receive.

When the Claims Administrator determines that You or Your Dependent may be eligible for benefits, the Claims Administrator may estimate the amount of these benefits. The Claims Administrator may reduce Your Weekly Benefit by the estimated amount.
Your Weekly Benefit will not be reduced by estimated Social Security disability benefits if:
1) You apply for Social Security disability benefits and pursue all required appeals in accordance with the Social Security provision; and
2) You have signed a form authorizing the Social Security Administration to release information about awards directly to the Claims Administrator.

If the Claims Administrator has reduced Your Weekly Benefit by an estimated amount and:
1) You or Your Dependent are later awarded Social Security disability benefits, the Claims Administrator will adjust Your Weekly Benefit when the Claims Administrator receives proof of the amount awarded, and determine if it was higher or lower than the Claims Administrator estimates; or
2) Your application for Social Security disability benefits has been denied, the Claims Administrator will adjust Your Weekly Benefit when You provide the Claims Administrator proof of final denial from which You cannot appeal from an Administrative Law Judge of the Office of Hearing and Appeals.

If Your Social Security benefits were lower than the Claims Administrator estimated, and the Claims Administrator owes You a refund, the Claims Administrator will make such refund in a lump sum. If Your Social Security Benefits were higher than the Claims Administrator estimated, and If Your Weekly Benefit has been overpaid, You must make a lump sum refund to the Claims Administrator equal to all overpayments, in accordance with the Overpayment Recovery provision

Subrogation: *What are the Employer's subrogation rights?*
If You:
1) suffer a Disability because of the act or omission of a Third Party;
2) become entitled to and are paid benefits under The Policy in compensation for lost wages; and
3) do not initiate legal action for the recovery of such benefits from the Third Party in a reasonable period of time;
then the Employer will be subrogated to any rights You may have against the Third Party and may, at its option, bring legal action against the Third Party to recover any payments made by The Plan in connection with the Disability.

Third Party as used in this provision means any person or legal entity whose act or omission, in full or in part, causes You to suffer a Disability for which benefits are paid or payable under The Policy.

Legal Actions: *When can legal action be taken against the Employer?*
Legal action cannot be taken against the Employer:
1) sooner than 60 days after the date proof of loss is furnished; or

2) more than 3 years after the date Proof of Loss is required to be furnished according to the terms of The Plan.

Misstatements: *What happens if facts are misstated?*
If material facts about You were not stated accurately, the true facts will be used to determine if, and for what amount, coverage should have been in force.

Plan Interpretation: *Who interprets the terms and conditions of The Plan?*
The Employer has full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of The Plan. This provision applies where the interpretation of The Policy is governed by the Employee Retirement Income Security Act of 1974, as amended (ERISA).

DEFINITIONS

Actively at Work means at work with Your Employer on a day that is one of Your Employer's scheduled workdays. On that day, You must be performing for wage or profit all of the regular duties of Your Occupation:
1) in the usual way; and
2) for Your usual number of hours.

You will be considered Actively at Work on a day that is not a scheduled work day only if You were Actively at Work on the preceding scheduled work day.

Active Employee means an employee who works for the Employer on a regular basis in the usual course of the Employer's business. This must be at least the number of hours shown in the Schedule of Benefits.

Bonuses means the weekly average of monetary bonuses You received from:
1) the Employer during the 12 month period immediately prior to the last day You were Actively at Work before You became Disabled;
2) the Employer during the total period of time You worked for the Employer, if less than the above period; or
3) any employer or for any work You perform during Your Period of Disability.

Claims Administrator means Hartford Comprehensive Employee Benefit Service Company (HARTFORD CEBSCO).

Commissions means the weekly average of monetary commissions You received from:
1) the Employer during the 12 month period immediately prior to the last day You were Actively at Work before You became Disabled; or
2) the Employer during the total period of time You worked for the Employer, if less than the above period; or
3) any employer or for any work You perform during Your Period of Disability.

Current Weekly Earnings means weekly earnings You receive from:
1) Your Employer; and
2) any other work for pay or profit;

while You are Disabled and eligible for the Disabled and Working Benefit. Current Weekly Earnings will include Bonuses and Commissions and will be pro-rated as necessary.

Disabled and Working means that You are prevented by:
1) Injury;
2) Sickness;
3) Mental Illness;
4) Substance Abuse; or
5) pregnancy

from performing some, but not all of the Essential Duties of Your Occupation, are working on a part-time or limited duty basis, and as a result, Your Current Weekly Earnings are more than 20%, but are less than or equal to 80% of Your Pre-disability Earnings.

Disability or Disabled means Total Disability or Disabled and Working Disability.

Essential Duty means a duty that:
1) is substantial, not incidental;
2) is fundamental or inherent to the occupation; and
3) cannot be reasonably omitted or changed.

Your ability to work the number of hours in Your regularly scheduled workweek is an Essential Duty.

Injury means bodily injury resulting:
1) directly from accident; and
2) independently of all other causes;

which occurs while You are covered under The Plan. However, an Injury will be considered a Sickness if Your Disability begins more than 30 days after the date of the accident.

Mental Illness means a mental disorder as listed in the current version of the Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association. A Mental Illness may be caused by biological factors or result in physical symptoms or manifestations.

For the purpose of The Plan, Mental Illness does not include the following mental disorders outlined in the Diagnostic and Statistical Manual of Mental Disorders:
1) Mental Retardation;
2) Pervasive Developmental Disorders;
3) Motor Skills Disorder;
4) Substance-Related Disorders;
5) Delirium, Dementia, and Amnesic and Other Cognitive Disorders; or
6) Narcolepsy and Sleep Disorders related to a General Medical Condition.

Other Income Benefits means the amount of any benefit for loss of income, provided to You or Your family, as a result of the period of Disability for which You are claiming benefits under The Plan. This includes any such benefits for which You or Your family are eligible or that are paid to You, or Your family or to a third party on Your behalf, pursuant to any:
1) temporary, permanent disability, or impairment benefits under a Workers' Compensation Law, the Jones Act, occupational disease law, similar law or substitutes or exchanges for such benefits;
2) governmental law or program that provides disability or unemployment benefits as a result of Your job with Your Employer;
3) plan or arrangement of coverage, whether insured or not, which is received from Your Employer as a result of employment by or association with Your Employer or which is the result of membership in or association with any group, association, union or other organization;
4) mandatory "no fault" automobile insurance plan;
5) disability benefits under:
   a) the United States Social Security Act or alternative plan offered by a state or municipal government;
   b) the Railroad Retirement Act;
   c) the Canada Pension Plan, the Canada Old Age Security Act, the Quebec Pension Plan or any provincial pension or disability plan; or
   d) similar plan or act;

   that You, Your spouse and/or children are eligible to receive because of Your Disability; or
6) disability benefit from the Department of Veterans Affairs, or any other foreign or domestic governmental agency:
   a) that begins after You become Disabled; or
   b) that You were receiving before becoming Disabled, but only as to the amount of any increase in the benefit attributed to Your Disability.

Other Income Benefits also means any payments that are made to You or Your family, or to a third party on Your behalf, pursuant to any:
1) temporary, permanent disability or impairment benefits under a Workers' Compensation Law, the Jones Act, occupational disease law, similar law or substitutes or exchanges for such benefits;
2) portion of a settlement or judgment, minus associated costs, of a lawsuit that represents or compensates for Your loss of earnings; or
3) retirement benefits under:
   a) the United States Social Security Act or alternative plan offered by a state or municipal government;
   b) the Railroad Retirement Act;
   c) the Canada Pension Plan, the Canada Old Age Security Act, the Quebec Pension Plan or any provincial pension or disability plan; or
   d) similar plan or act;

   that You, Your spouse and/or children receive because of Your retirement, unless You were receiving them prior to becoming Disabled.

Other Income Benefits will not include:

1) early retirement benefits under the United States Social Security Act that are not received;
2) the amount of any increase in benefits paid under any federal or state law, if the increase:
   a) takes effect after the date benefits become payable under The Plan; and
   b) is a general increase which is required by law and applies to all persons who are entitled to such benefits;
3) group credit or mortgage disability insurance benefits;
4) any benefits or proceeds from:
   a) personal investment income;
   b) Veteran's Administration Disability and military retirement benefits You are receiving prior to becoming Disabled;
   c) a military retirement pension plan;
   d) defined contribution plan from a professional corporation;
   e) individual or Employer sponsored IRA or tax sheltered annuity, or deferred compensation plan;
   f) employee stock option plan or any thrift plan;
   g) a partner or proprietor H.R. 10 (Keogh) plan under the self-employed individual Retirement Act;
   h) a capital account; or
   i) individual insurance benefits.

If You are paid Other Income Benefits in a lump sum or settlement, You must provide proof satisfactory to the Claims Administrator of:
1) the amount attributed to loss of income; and
2) the period of time covered by the lump sum or settlement.

The lump sum or settlement will be pro-rated over this period of time. If You cannot or do not provide this information, it will be assumed the entire sum to be for loss of income and the time period to be 60 months. A retroactive allocation may be made of any retroactive Other Income Benefit. A retroactive allocation may result in an overpayment of Your claim.

The amount of any increase in Other Income Benefits will not be included as Other Income Benefits if such increase:
1) takes effect after the date benefits become payable under The Plan; and
2) is a general increase which applies to all persons who are entitled to such benefits.

Participating Employer means an Employer who agrees to participate in the Trust, pays the required contribution for the Active Employees and is a participant in accordance with the provisions of The Plan.

Physician means a person who is:
1) a doctor of medicine, osteopathy, psychology or other legally qualified practitioner of a healing art that the Claims Administrator recognize or are required by law to recognize;
2) licensed to practice in the jurisdiction where care is being given;
3) practicing within the scope of that license; and
4) not You or Related to You by blood or marriage.

Pre-disability Earnings means Your regular weekly rate of pay from Your Employer, not counting Bonuses and Commissions, in effect during the last full calendar month that You were Actively at Work before You became Disabled.

Pre-disability Earnings does not include any other fringe benefits or extra compensation. In addition, earnings from overtime or on-call hours are not included unless regularly scheduled.

However, if You are an hourly paid Employee, Pre-disability Earnings means the product of:
1) the average number of hours You worked per week, including hours from paid vacation, sick time, overtime (if regularly scheduled) and other paid time off, not including on-call hours, over the most recent 12 month period immediately prior to the last day You were Actively at Work before You became Disabled, multiplied by:
2) Your hourly wage in effect on the last day You were Actively at Work before You became Disabled.

Pre-disability Earnings includes contributions You make through a salary reduction agreement with the Employer to:
1) an Internal Revenue Code (IRC) Section 401(k), 403(b) or 457 deferred compensation arrangement;
2) an executive non-qualified deferred compensation arrangement; or
3) a salary reduction arrangement under an IRC Section 125 plan,

for the same period as above.

Prior Plan means the short term disability plan carried by the Employer on the day before the Plan Effective Date.

Regular Care of a Physician means that You are being treated by a Physician:

1) whose medical training and clinical experience are suitable to treat Your disabling condition; and
2) whose treatment is:
   a) consistent with the diagnosis of the disabling condition;
   b) according to guidelines established by medical, research, and rehabilitative organizations; and
   c) administered as often as needed;

to achieve the maximum medical improvement.

Related means Your spouse or other adult living with You, sibling, parent, step-parent, grandparent, aunt, uncle, niece, nephew, son, daughter, or grandchild or someone in a similar relationship in law to You.

Sickness means a Disability which is:

1) caused or contributed to by:
   a) any condition, illness, disease or disorder of the body;
   b) any infection, except a pus-forming infection of an accidental cut or wound or bacterial infection resulting from an accidental ingestion of a contaminated substance;
   c) hernia of any type unless it is the immediate result of an accidental Injury covered by The Plan; or
2) caused or contributed to by any medical or surgical treatment for a condition shown in item 1) above.

Substance Abuse means the pattern of pathological use of alcohol or other psychoactive drugs and substances characterized by:

1) impairments in social and/or occupational functioning;
2) debilitating physical condition;
3) inability to abstain from or reduce consumption of the substance; or
4) the need for daily substance use to maintain adequate functioning.

Substance includes alcohol and drugs but excludes tobacco and caffeine.

The Plan means the Plan which the Claims Administrator issued to the Contractholder under the Plan number in the Schedule of Benefits.

Total Disability or Totally Disabled means that You are prevented by:

1) Injury;
2) Sickness;
3) Mental Illness;
4) Substance Abuse;

from performing the Essential Duties of Your Occupation, and as a result, You are earning less than 20% of Your Pre-disability Earnings.

Your Occupation means Your Occupation as it is recognized in the general workplace, that You were routinely performing prior to becoming Disabled. Your Occupation does not mean the specific job You are performing for a specific employer or at a specific location.

If You are a Physician, Your Occupation means the general or sub-specialty in which You are practicing for which there is a specialty or sub-specialty recognized by the American Board of Medical Specialties. If the sub-specialty in which You are practicing is not recognized by the American Board of Medical Specialties, You will be considered practicing in the general specialty category.

You or Your means the person to whom this Plan is issued.

ERISA INFORMATION
THE FOLLOWING NOTICE
CONTAINS IMPORTANT INFORMATION

This employee welfare benefit plan (Plan) is subject to certain requirements of the Employee Retirement Income Security Act of 1974 (ERISA), as amended. ERISA requires that you receive a Statement of ERISA Rights, a description of Claim Procedures, and other specific information about the Plan. This document serves to meet ERISA requirements and provides important information about the Plan.

The benefits described in your Plan document are provided under a group plan sponsored by the Employer and are subject to the terms and conditions of that Plan. The Employer has the full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of the Plan.

A copy of this plan is available for your review during normal working hours in the office of the Plan Administrator.

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1. **Plan Name**

   Group Short Term Disability Plan for Employees of NORTHWEST PERMANENTE, P.C..

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2. **Plan Number**

   WD - 509

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3. **Employer/Plan Sponsor**

   NORTHWEST PERMANENTE, P.C.
   500 Ne Multnomah
   Suite 100
   Portland, OR 97232-2031

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4. **Employer Identification Number**

   93-0698548

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5. **Type of Plan**

   Welfare Benefit Plan providing Group Short Term Disability.

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6. **Plan Administrator**

   NORTHWEST PERMANENTE, P.C.
   500 Ne Multnomah
   Suite 100
   Portland, OR 97232-2031

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7. **Agent for Service of Legal Process**

For the Plan:

NORTHWEST PERMANENTE, P.C.
500 Ne Multnomah
Suite 100
Portland, OR 97232-2031

For the Claims Administrator:

Hartford Comprehensive Employee Benefit Service Company (Hartford CEBSCO)
200 Hopmeadow St.
Simsbury, CT 06089

In addition to the above, Service of Legal Process may be made on a plan trustee.

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8. **Sources of Contributions** The Employer pays the premium for the insurance, but may allocate part of the cost to the Employee, or the Employee may pay the entire premium. The Employer determines the portion of the cost to be paid by the Employee. The insurance company/provider determines the cost according to the rate structure reflected in the Policy of Incorporation.

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9. **Type of Administration** The plan is administered by the Plan Administrator with benefits provided in accordance with the provisions of the applicable Plan Document.

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10. The Plan and its records are kept on a Plan year basis.

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11. **Labor Organizations**

None

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12. **Names and Addresses of Trustees**

None

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13. **Plan Amendment Procedure**

The Plan Administrator reserves full authority, at its sole discretion, to terminate, suspend, withdraw, reduce, amend or modify the Plan, in whole or in part, at any time, without prior notice.

The Employer also reserves the right to adjust your share of the cost to continue coverage by the same procedures.

Statement of ERISA Rights

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), as amended. ERISA provides that all Plan participants shall be entitled to:

1. Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary Plan description. The administrator may make a reasonable charge for the copies.
Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

2. Prudent Actions by Plan Fiduciaries:

In addition to creating rights for Plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate your Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

3. Enforce Your Rights:

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If the Plan requires you to complete administrative appeals prior to filing in court, your right to file suit in state or Federal court may be affected if you do not complete the required appeals. If it should happen that Plan fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

4. Assistance with Your Questions:

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (formerly known as the Pension and Welfare Benefits Administration), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210 . You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

CLAIM PROCEDURES

The Employer has the full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of the Plan.

Claim Procedures for Claims Requiring a Determination of Disability.

Claims for Benefits:

If you or your authorized representative would like to file a claim for benefits for yourself or your insured dependents, you or your authorized representative should obtain a claim form(s) from your Employer or Plan Administrator. The applicable section of such form(s) must be completed by (1) you, (2) the Employer or Plan Administrator and (3) the attending physician or hospital. Following completion, the claim form(s) must be forwarded to the Claim Administrator. The Claim Administrator will evaluate your claim and determine if benefits are payable.

The claim decision will be made no more than 45 days after receipt of your properly filed claim. The time for decision may be extended for two additional 30 day periods provided that, prior to any extension period, you are notified in writing that an extension is necessary due to matters beyond the control of the Plan, that the notice identifies those matters and gives the date by which a decision is expected to be made. If your claim is extended due to your failure to submit information necessary to decide your claim, the time for decision may be tolled from the date on which the notification of the extension is sent to you until the date we receive your response to our request. If the Claim Administrator approves your claim, the decision will contain information sufficient to reasonably inform you of that decision.

Any adverse benefit determination will be in writing and include: 1) specific reasons for the decision, 2) specific references to the Plan provisions on which the decision is based, 3) a description of any additional material information necessary for you to perfect the claim and an explanation of why such material or information is necessary, 4) a description of the review procedures and time limits applicable to such procedures, 5) a statement that you have the right to bring a civil action under section 502(a) of ERISA after you appeal the decision and after you receive a written denial on appeal, and 6)(A) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the denial, either (i) the specific rule, guideline, protocol or other similar criterion, or (ii) a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the denial and that a copy will be provided free of charge to you upon request, or (B) if denial is based on medical judgment, either (i) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or (ii) a statement that such explanation will be provided to you free of charge upon request.

Appealing Denial of Claims for Benefits:

On any wholly or partially denied claim, you or your representative may appeal to the Employer for a full and fair review. Your appeal request must be in writing and be received by the Employer no later than the expiration of 180 days from the date you received your claim denial.

As part of your appeal:

1. you may request, free of charge, copies of all documents, records, and other information relevant to your claim; and
2. you may submit written comments, documents, records and other information relating to your claim.

The Employer's review on appeal shall take into account all comments, documents, records and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

The Employer will make a final decision no more than 45 days after it receives your timely appeal. The time for final decision may be extended for one additional 45 day period provided that, prior to the extension, the Employer notifies you in writing that an extension is necessary due to special circumstances, identifies those circumstances and gives the date by which it expects to render its decision. If your claim is extended due to your failure to submit information necessary to decide your claim on appeal, the time for decision shall be tolled from the date on which the notification of the extension is sent to you until the date the Employer receives your response to the request.

The individual reviewing your appeal shall give no deference to the initial benefit decision and shall be an individual who is neither the individual who made the initial benefit decision, nor the subordinate of such individual. The review process provides for the identification of the medical or vocational experts whose advice was obtained in connection with an initial adverse decision, without regard to whether that advice was relied upon in making that decision. When deciding an appeal that is based in whole or part on medical judgment, the Employer will consult with a medical professional having the appropriate training and experience in the field of medicine involved in the medical judgment and who is neither an individual consulted in connection with the initial benefit decision, nor a subordinate of such individual. If the Employer grants your claim appeal, the decision will contain information sufficient to reasonably inform you of that decision.

However, any final adverse benefit determination on review will be in writing and include: 1) specific reasons for the decision, 2) specific references to the Plan provisions on which the decision is based, 3) a statement that you have the right to bring a civil action under section 502(a) of ERISA, 4) a statement that you may request, free of charge, copies of

all documents, records, and other information relevant to your claim; 5)(A) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the decision on appeal, either (i) the specific rule, guideline, protocol or other similar criterion, or (ii) a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the decision on appeal and that a copy will be provided free of charge to you upon request, or (B) if the decision on appeal is based on medical judgment, either (i) an explanation of the scientific or clinical judgment for the decision on appeal, applying the terms of the Plan to your medical circumstances, or (ii) a statement that such explanation will be provided to you free of charge upon request, and 6) any other notice(s), statement(s) or information required by applicable law.

Claim Procedures for Claims Not Requiring a Determination of Disability

Claims for Benefits

If you or your authorized representative would like to file a claim for benefits for yourself or your insured dependents, you or your authorized representative should obtain a claim form(s) from your Employer or Plan Administrator. The applicable section of such form(s) must be completed by (1) you, (2) the Employer or Plan Administrator and (3) the attending physician or hospital. Following completion, the claim form(s) must be forwarded to the Claim Administrator. The Claim Administrator will evaluate your claim and determine if benefits are payable.

The claim decision will be made no more than 90 days after receipt of your properly filed claim. However, if there are special circumstances that require an extension, the time for claim decision will be extended for an additional 90 days, provided that, prior to the beginning of the extension period, you are notified in writing of the special circumstances and are given the date by which a decision is expected to be made. If extended, a decision shall be made no more than 180 days after your claim was received. If the Claim Administrator approves your claim, the decision will contain information sufficient to reasonably inform you of that decision.

However, any adverse benefit determination will be in writing and include: 1) specific reasons for the decision; 2) specific references to Plan provisions on which the decision is based; 3) a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary; 4) a description of the review procedures and time limits applicable to such, and 5) a statement that you have the right to bring a civil action under section 502(a) of ERISA after you appeal the decision and after you receive a written denial on appeal.

Appealing Denials of Claims for Benefits

On any wholly or partially denied claim, you or your representative may appeal to the Employer for a full and fair review. Your appeal request must be in writing and be received by the Employer no later than the expiration of 60 days from the date you received your claim denial.

As part of your appeal:

1. you may request, free of charge, copies of all documents, records, and other information relevant to your claim; and
2. you may submit written comments, documents, records and other information relating to your claim.

The Employer's review on appeal shall take into account all comments, documents, records and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

The Employer will make a final decision no more than 60 days after it receives your timely appeal. However, if the Employer determines that special circumstances require an extension, the time for its decision will be extended for an additional 60 days, provided that, prior to the beginning of the extension period, the Employer notifies you in writing of the special circumstances and gives the date by which it expects to render its decision. If extended, a decision shall be made no more than 120 days after your appeal was received. If the Employer grants your claim appeal, the decision will contain information sufficient to reasonably inform you of that decision.

However, any final adverse benefit determination on review will be in writing and include: 1) specific reasons for the decision and specific references to the Plan provisions on which the decision is based, 2) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim, 3) a statement of your right to bring a civil action under section 502(a) of ERISA, and 4) any other notice(s), statement(s) or information required by applicable law.

AMENDMENT TO GROUP PLAN GRH-072800 PROCESSED ON JANUARY 26, 2016. ANY CHANGES BETWEEN THIS PLAN AND THE PREVIOUSLY ISSUED PLAN ARE EFFECTIVE JANUARY 1, 2016. ALL OTHER TERMS, CONDITIONS AND DATES REMAIN UNCHANGED.

AMENDMENT TO GROUP ACCOUNT NO. 072800 PROCESSED ON JANUARY 1, 2016. CHANGES MADE BY THIS RIDER ARE EFFECTIVE JANUARY 1, 2016. ALL OTHER TERMS, CONDITIONS AND DATES REMAIN UNCHANGED.

PLAN DESCRIPTION

NORTHWEST PERMANENTE, P.C.

This Document is intended to establish the terms and conditions of the employee benefit plan (hereinafter referred to as "Plan") established by NORTHWEST PERMANENRE, P.C. (hereinafter referred to as the Employer) for the purpose of providing short term disability benefits. The Plan is applicable to the Employer's eligible employees. Rules determining eligibility and benefit payments, as well as other rules pertaining to the Plan, are set forth in the short term disability benefits booklet(s) and any endorsement(s) attached to, and forming a part of, this Plan Document.

The Named Fiduciary and Plan Administrator is the Employer, which has full authority to manage the operation and administration of the Plan. The Claims Evaluator shall be Hartford-Comprehensive Employee Benefit Service Company (HARTFORD-CEBSCO). The Plan Administrator shall have the authority to amend the Plan, to determine its policies, and to appoint and remove the Claims Evaluator or any other parties in interest engaged to administer the Plan.

The Plan Effective Date shall be 01/01/2016.

The amount of contributions to the Plan are to be made on the following basis:

1) The Employer shall from time to time evaluate the costs of the Plan and determine the amount to be contributed by the Employer and the amount to be contributed (if any) by each covered employee.
2) Funds required for the operation of the Plan and for the payment of short term disability claims are accumulated by means of employee payroll deductions and Company contributions. All funds received by the Plan shall be applied toward payment of short term disability claims and reasonable administrative expenses of the Plan.

The Employer shall have the right at any time to amend, modify, terminate or partially terminate the Plan. In the event of Plan termination or partial termination, all previous contributions by the Employer shall continue to provide for the payment of benefits under the provisions of the Plan with respect to claims arising before any such Plan termination, or shall be used for the purpose of providing similar short term disability benefits to covered employees until all Plan funds are exhausted.

Any Plan change must be in writing and will not require the consent of any employee. Changes so made shall be binding on each covered employee referred to in this Plan Document. Only the Company can change the provisions of this Plan Document. No clerical error will invalidate coverages described herein if they are otherwise validly in force.

No failure to enforce any provision of this Plan shall affect the right thereafter to enforce such provision, nor shall such failure affect the right to enforce any other provision of this Plan.

IN WITNESS WHEREOF, the Employer has executed and agreed upon this Plan Document this first day of January, 2016.

For the Employer:

By

Title

Attest

Title

INCORPORATION PROVISION

Booklet
The short term disability benefits booklet(s) which are attached to this Plan Document are hereby incorporated in, and made a part of, this Plan Document.

Booklet Form(s):
(072800) ASO-STD 5.10
(072800) ASO-STD 6.05
(072800) ASO-STD 7.04
(072800) ASO-STD 8.04

The terms found in the Plan booklet(s) and any booklet rider(s) will control:

1) the benefit plan provisions, amounts and maximum limits;
2) the eligibility and effective date of coverage rules;
3) the termination of coverage rules;
4) exclusions; and
5) other general plan provisions.